Fully Functioning Aging and Disability Resource Centers

June 2010

These criteria were developed to assist states measure and assess their progress toward developing fully functioning Single-Entry-Point/Aging and Disability Resource Centers (ADRCs). These criteria and recommended metrics are intended to be applicable across different types of ADRC models. The term "ADRC" in this document may be interpreted to represent one primary operating organization in each community, a network of organizations serving as operating partners in each community ("no wrong door" model), or a combination of state level and local level organizations operating in partnership. Metrics that should be interpreted differently or applied differently to systems with a single operating entity/single entry point or multiple operating partners/multiple entry points are noted.

Program Component/ Core Function	Definition and Purpose	Recommended Criteria/ Metrics
Information, Referral and Awareness	The *Information, Referral and Awareness* function of an ADRC is defined by the ADRC's ability to serve as a highly visible and trusted place where people of all ages, disabilities and income levels know they can turn to for objective information on the full range of long-term service and support options. It is also defined by its ability to promote awareness of the various options that are available in the community, especially among underserved, hard-to-reach and private paying populations, as well as options individuals can use to plan ahead for their long-term care. Finally, ADRCs should have the capacity to link consumers with needed services and supports – both public and private - through appropriate referrals to other agencies and organizations.	Outreach and Marketing • ADRC has a proven outreach and marketing plan focused on establishing operating partners as highly visible and trusted places where people can turn for the full range of long-term support options as well as raising awareness in the community about long term supports and services options. The outreach and marketing plan includes: a) consideration of all the populations they serve including different age groups, people with different types of disabilities, culturally diverse groups, underserved and unserved populations, individuals at risk of nursing home placement, family caregivers and professionals b) a strategy to assess the effectiveness of the outreach and marketing activities; and c) a feedback loop to modify activities as needed. • ADRC actively markets to and serves private pay consumers in addition to those that require public assistance. Information and Referral • ADRC uses systematic processes across all operating partners to

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		provide information and referral/ assistance.
		• Whether the ADRC has single or multiple entry points within the service area, all operating partners use the same comprehensive resource database with information about the range of long term supports and resources in the ADRC service area.
		- A system is in place for updating and ensuring the accuracy of the information provided.
		- Resources in the database conform to established inclusion/exclusion policies; these policies specifically address inclusion of resources and providers for private paying individuals and families.
		- The database is accessible to the public via a comprehensive website and is user friendly, searchable and accessible to persons with disabilities.
		• ADRC consistently conducts follow-up with individuals receiving I&R/A to determine whether more assistance is needed.
Options Counseling and Assistance	The Options Counseling and Assistance function is defined by the ADRC's ability to provide counseling and decision support, including one-on-one assistance, to consumers and their family members and/or caregivers. The main purpose of Options Counseling and Assistance is to help consumers assess and understand their needs, and to assist them in making informed decisions about appropriate long-term service and support choices – as well as their Medicare options - in the context of their personal needs, preferences, values and individual circumstances. Options Counseling and Assistance may also entail helping consumers to develop service	Options Counseling • Standards and protocols are in place that define what options counseling entails and who will be offered options counseling. At a minimum, this will include any consumer who requests it and consumers who go through a comprehensive assessment process. • ADRC has the capability, through a single or multiple operating partners, to provide objective, accurate and comprehensive long term support options counseling to consumers with different types of disabilities and families of all income levels. • All ADRC operating partners that serve as entry points for consumers use standard intake and screening instruments. • Options counseling sessions are conducted by staff trained and

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	plans and arranging for the delivery of services and supports, including helping individuals to hire and supervise their direct care workers. Individuals and families who receive options counseling should be in better position to make service and support choices that optimally meet their needs and preferences, and be able to make better use their own personal and financial resources in the short term and over time.	qualified to provide objective, person-centered assistance to consumers in the process of making decisions, as evidenced by certification, minimum qualifications and/or training/cross-training practices. • ADRC provides intensive support to individuals in short-term crisis situations until long term support arrangements have been made. • ADRC consistently conducts follow-up to individuals receiving options counseling to determine the outcome and whether more assistance is needed. • ADRC provides individuals and families with assistance in planning for future long term supports and services needs directly or contractually by staff who possess specific skills related to LTC needs planning and financial counseling.
Streamlined Eligibility Determination for Public Programs	Long-term services and supports are funded by a variety of different government programs administered by a wide array of federal, state and local agencies, each with its own eligibility rules, procedures and paperwork requirements. The Streamlined Eligibility Determinations for Public Programs component of an ADRC is defined by its ability to serve as a single point of entry to all publicly funded long-term supports, including those funded by Medicaid, the Older Americans Act (OAA), and other state and federal programs and services. This requires ADRCs to have the necessary protocols and procedures in place to facilitate an integrated and/or fully coordinated approach to performing the following administrative functions for all public programs (including both home and community-based services programs and	Intake and Screening • ADRC has a standardized process for helping consumers access all publicly-funded long term supports and service programs available in the state. • In multiple entry point systems, the intake and screening process is coordinated and standardized so that consumers experience the same process wherever they enter the system. Financial and Functional Eligibility Processes • Financial and functional/clinical eligibility determination processes for public programs are highly coordinated by the ADRC, so consumers experience it all as one process. • ADRC uses uniform criteria to assess risk of institutional placement in order to target support to individuals at high-risk. • Staff located on-site within the ADRC conduct level of care assessments that are used for determining functional/clinical eligibility, or ADRC has a formal process in place for seamlessly

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	institutional-based programs): • consumer intake • screening • assessing an individual's needs • developing service/care plans • determining programmatic and financial eligibility • ensuring that people receive the services for which they are eligible The goal is to create a process that is both administratively efficient and seamless for consumers regardless of which program they end of being eligible for or the types of services they receive.	referring consumers to the agency that conducts level of care assessments. • ADRC staff assist consumers as needed with initial processing functions (e.g., taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews). • Staff located on-site within the ADRC can determine financial eligibility (staff co-located from or delegated by the Single State Medicaid Agency), or ADRC staff can submit completed applications to the agency authorized to determine financial eligibility directly on behalf of consumers. Tracking Eligibility Status • ADRC is able to track individual consumers' eligibility status throughout the process of eligibility determination and redetermination. • ADRC is routinely informed of consumers who are determined ineligible for public LTC programs or services and the ADRC conducts follow-up with those individuals. • In localities where waiting lists for public LTC programs or services exist, the ADRC is routinely informed of consumers who are on the waiting list and conducts follow-up with those individuals.

Person-Centered Transition Support	The Person-Centered Transitions component is defined by an ADRC's ability to create formal linkages between and among the major pathways that people travel while transitioning from one setting of care to another or from one public program payer to another. These pathways include preadmission screening	• ADRC has formal agreements with local critical pathway providers such as hospitals, physician's offices, nursing homes and ICFs-MR that include:
		
		   (1) An established process for identifying individuals and their caregivers who may need transition support services
		
		   (2) Protocols for referring individuals to the ADRC for

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	programs for nursing home services and hospital discharge planning programs, and they represent critical junctures where decisions are made – usually in a time of crisis - that often determine whether a person ends up in a nursing home or is transitioned back to their own home. The ADRC can play a pivotal role in these transitions to ensure that people end up in the settings that best meet their individual needs and preferences, which is often in their own homes. ADRC staff can be present at these critical points to provide individuals and their families with the information they need to make informed decisions about their service and support options, and to help them to quickly arrange for the care and services they choose. These critical activities can help individuals avoid being placed unnecessarily in a nursing home. They can also break the cycle of readmission to the hospital that often occurs when a chronically impaired individual is discharged to the community without the social services and supports they need.	transition support and other services; (3) Regular training for facility administrators and discharge planners about the ADRC • ADRC works with the State Medicaid Agency to become Local Contact Agencies (LCAs) to provide transitions services for institutionalized individuals who indicate they wish to return to the community via the MDS 3.0 Section Q assessment.
Consumer Populations, Partnerships and Stakeholder Involvement	Many ADRCs started out serving older adults and one other target population, such as adults with physical disabilities, intellectual or developmental disabilities, or mental illness. ADRCs should work towards the goal of serving persons with disabilities of all ages and types. To be truly person-centered, ADRCs must meaningfully involve stakeholders, including consumers, in planning, implementation and	Consumer Populations • ADRC serves individuals with all types of disabilities, either through a single operating organization or through close coordination with multiple operating partners. • ADRC staff demonstrate competencies relating to serving people of all ages and types of disabilities and their families. • There are formal mechanisms for involving consumers on state/local ADRC advisory boards or governing committee and in

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	quality assurance activities.	planning, implementation and evaluation activities.
	In order to function efficiently and serve as the single entry point for the full array of long term services and supports programs in the state, ADRCs must have the documented support and active participation of the Single State Agency on Aging, the Single State Medicaid Agency and the State Agency(s) serving the target populations(s) of people with disabilities. ADRCs should also establish strong partnerships with the State Health Insurance Assistance Program (SHIP), Adult Protective Services, Benefit Outreach and Enrollment Centers, and other programs instrumental to ADRC activities. Examples of other important programs and partners to cultivate include Area Agencies on Aging, Centers for Independent Living, Alzheimer's disease programs, Developmental Disabilities Councils, Information and Referral/2-1-1 programs, Long-Term Care Ombudsman programs, housing agencies, transportation authorities, State Mental Health Planning Councils, One-Stop Employment Centers and other community-based organizations.	Medicaid • ADRC has formal partnership agreements at the local level (or at the state level if applicable across all sites) with Medicaid agency(ies) that describe explicitly the role of each partner in the eligibility determination process and information sharing policies. • ADRC staff are involved as partners or key advisors in other state long term support and services system reform initiatives (e.g. Money Follows the Person initiatives) Aging and Disability Partners • In multiple entry point systems, the ADRC has formal service standards, protocols for information sharing, and cross-training across all operating partners. • In single entry point systems, there is strong collaboration, including formal agreements, at the state and local levels between critical aging and disability agencies and service organizations. Stakeholders • If the State Health Insurance Assistance Program (SHIP), Adult Protective Services, and local 2-1-1 programs are operated by entities separate from the ADRC, there is a MOU or Interagency Agreement establishing, at a minimum, a protocol for mutual referrals between the ADRC and these three programs. • There is evidence of strong collaboration with other programs and services instrumental to ADRC activities.
Quality Assurance and Continuous	Quality Assurance and Continuous Improvement is a part of every ADRC system to ensure adherence to the highest standard of service, as	Staffing • ADRC has adequate capacity to assist consumers in a timely manner with long term support requests and referrals, including

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Improvement	well as to ensure public and private investments in ADRCs are producing measurable results.

ADRCs should be using electronic information systems to track their customers, services, performance and costs, and to continuously evaluate and improve on the results of the ADRC services that are provided to individual consumers and their families, as well as to other organizations in the community. This can include linkages with other data systems, such as Medicaid information systems and electronic health records.

The Quality Assurance and Continuous Improvement component of an ADRC should also involve formal processes for getting input and feedback from consumers and their families on the ADRC's operations and on-going development. Every ADRC should have measurable performance goals and indicators related to its visibility, trust, ease of access, consumer responsiveness, efficiency and effectiveness. | referrals from critical pathway providers.

• In multiple entry points systems, the ADRC has one overall coordinator or manager with sufficient authority to maintain quality processes across agencies.

IT/MIS

• ADRC operating organizations use management information systems that support all program functions.

• ADRC has established an efficient process for sharing resource and client information electronically across operating partners and with external entities, as needed, from intake to service delivery.

Continuous Improvement

• ADRC has a plan in place to monitor program quality and a process to ensure continuous program improvement through the use of the data gathered such as consumer satisfaction evaluations.

• ADRC informs consumers of complaint and grievance policies and has the ability to track and address complaints and grievances.

Performance Tracking

• ADRC routinely tracks service delivery and consumer outcomes and can demonstrate:

    o That the ADRC serves people in different age groups, with different types of disabilities and income levels in proportions that reflect their relative representation in the community.

    o That options counseling provided enables people to make informed, cost-effective decisions about long-term care services. |

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		o Number of individuals diverted from nursing home/institutional settings.
		o Number of individuals successfully transitioning from institutional settings (i.e. number of people assisted through formal coordinated transitions programs).
		• States operating ADRCs evaluate their overall impact in the following areas:
		o Reduction in the average time from first contact to eligibility determination for publicly funded home and community-based services.
		o Impact on the use of home and community based services vs. institutional services.
		o Documentation of the cost impact to public programs, including Medicaid.